ACTIVE LIFE CHIROPRACTIC
a Sports Injury & Family Practice

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AUTO INJURY HISTORY

~ Please answer all questions completely ~

Name: _____ **Today's Date:** _____
First Middle Last

Address: _____
Street Apt# City State Zip

Cell phone: (____) _____ **Home phone: (____)** _____ **Email:** _____

Date of Birth: _____ **Gender:** _____ **Marital Status:** _____ **SS #:** _____

Employer/Occupation: _____ **Phone: (____)** _____

Employer Address: _____
Street City State Zip

Emergency Contact/Relationship: _____ **Phone: (____)** _____

Accident Details

Date _____ Time _____ **Location** _____ City_____ State_____

Patient's Auto Insurance Company _____ ☐ **At Fault ?**
Policy # _____ Claim # _____
Name Insurance Adjustor _____
Phone # _____ Fax # _____

Name of the driver of other vehicle _____ Phone # _____
Other Driver's Auto Insurance Company _____ ☐ **At Fault ?**
Policy # _____ Claim # _____
Name Insurance Adjustor _____
Phone # _____ Fax # _____

Name of the driver of vehicle if you were a passenger _____ Phone # _____
Driver's Auto Insurance Company _____ ☐ **At Fault ?**
Policy # _____ Claim # _____
Name Insurance Adjustor _____
Phone # _____ Fax # _____

HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO
Name of Attorney _____ Phone # _____
Name contact/legal assistant _____ Fax # _____

Please describe your accident _____
_____
_____

Were you heading: North ☑ South ☐ East ☐ West ☐ On (street or highway) _____
Other vehicle was heading: North ☑ South ☐ East ☐ West ☐ On (street or highway) _____

Road conditions at the time of accident: ☐Wet ☐Dry ☐Icy ☐Other _____

Did the police come to the accident scene? ☐Yes ☐No Is there a report? ☐Yes ☐No

Did the EMS come to the accident scene? ☐Yes ☐No Did they evaluate you on scene? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No If Yes, Which hospital? _____
How did you arrive there? ☐Ambulance ☐someone else drove ☐I drove

Were parts of your body imaged at the hospital? ☐Yes ☐No Which? _____
Findings on images? ☐Yes ☐No _____ Diagnosis? _____
What treatment was given? _____ Is it helping? ☐Yes ☐No

Was another doctor consulted after your accident? ☐Yes ☐No Doctor's name _____
Any other treatment? _____

Vehicle Description (for the vehicle you were in)

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? ☐Yes ☐No
If "yes" was the driver's foot also on the brake? ☐Yes ☐No
If "no" please estimate the speed of the vehicle you were in _____ m.p.h.
If the vehicle was moving at the time of impact, was it: Slowing down? ☐Yes ☐No
Gaining speed? ☐Yes ☐No Traveling at a steady rate of speed? ☐Yes ☐No

Where was this vehicle impacted during the collision? _____

What is the cost damage to this vehicle? _____

What of the following car parts broke during the accident?:
☐Windshield ☐Front seat back ☐Right/left side window ☐Steering wheel ☐Other _____

Vehicle Description (for the other vehicle)

Year _____ Make _____ Model _____

Was the other vehicle stopped at the time of impact? ☐Yes ☐No
If "no" please estimate the speed that vehicle was moving_____ m.p.h.
If the vehicle was moving at the time of impact, was it: Slowing down? ☐Yes ☐No
Gaining speed? ☐Yes ☐No Traveling at a steady rate of speed? ☐Yes ☐No

Where was this vehicle impacted during the collision? _____

What is the cost damage to this vehicle? _____

What of the following car parts broke during the accident?:
☐Windshield ☐Front seat back ☐Right/left side window ☐Steering wheel ☐Other _____

Patient Name _____ DOB _____

Where were you seated in the vehicle you were in? _____ Were you aware of the approaching collision or did the impact catch you by surprise? _____ Did you attempt to brace for impact? ☐ Yes ☐ No

Did you hit your head? ☐ Yes ☐ No Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No
If you did lose consciousness, estimate for how long _____

Were you wearing a seatbelt? ☐ Yes ☐ No lap seatbelt or shoulder-lap seatbelt Any bruising from the belt? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No
Any other bleeding or bruising obtained during this accident? ☐ Yes ☐ No _____
Any other body parts take an impact during this accident? ☐ Yes ☐ No _____

Which direction were you facing during the accident? _____

Check symptoms you have noticed since accident:

☐ Irritability	☐ Numbness in Toes	☐ Chest Pain	☐ Dizziness
☐ Heavy Head	☐ Tingling in Legs	☐ Tingling in Arms	☐ Numbness in fingers
☐ Shortness of Breath	☐ Fatigue	☐ Depression	☐ Eyes Sensitive to Light
☐ Memory Loss	☐ Ringing of Ears	☐ Face Flushing	☐ Buzzing in Ears
☐ Loss of balance	☐ Fainting	☐ Loss of Smell	☐ Loss of taste
☐ Diarrhea	☐ Cold Feet	☐ Cold Hands	☐ Upset Stomach
☐ Constipation	☐ Cold sweats	☐ Fever	☐ Headache
☐ Neck Pain	☐ Stiff Neck	☐ Sleeping Problems	☐ Back Pain
☐ Nervousness	☐ Tension	☐ Shoulder Pain	☐ Jaw Pain/Clicking
☐ Other _____	☐ Knee Pain	☐ Nausea/Vomiting	

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, last day worked_____

Body region 1 (Most painful/problematic)

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity 1 /10 Current pain intensity 10 Worst pain intensity 10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____
When did you first notice symptoms in this area? _____

Patient Name _____ DOB _____

Body region 2

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity 10 Worst pain intensity 10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____
When did you first notice symptoms in this area? _____

Body region 3

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity 4 /10 Current pain intensity 10 10 Worst pain intensity 10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____
When did you first notice symptoms in this area? _____

List up to 6 of your normal activities that your symptoms make difficult for you to complete. Rate your ability to perform these on a 0-10 scale with 10 being completely able to perform and 0 being completely unable to perform.

1)_____ Rating_____/10 2)_____ Rating_____/10

3)_____ Rating_____/10 4)_____ Rating_____/10

5)_____ Rating_____/10 6)_____ Rating_____/10

Have you seen a chiropractor before? ____ If yes, Whom/How did they adjust you/Were they effective/What do you wish they would have done differently _____

Patient Name _____ DOB _____

Any **weight change** not initiated by you over the past couple of months How much _____

Night pain that wakes you from sleeping _____ **History of cancer** and When? _____
Any **bowel or bladder** changes recently/Explain _____

What are your **treatment goals** for this injury _____
Do you have any life events you are working toward _____

Any **major illnesses or hospitalizations or surgeries** _____
Any **general traumas** such as car accidents or sporting accidents _____
Have you ever been **knocked unconscious** ____ When _____
Any Hardware/Replacements? _____ **Where** _____

Did last physical include a PAP/Breast exam or Prostate check: Y/N **When**: _____ **Any Concerns/Positives**? ___
_____

Medications/Supplements/Vitamins (including over-the-counter)_____
_____

Family History of any health condition present or past (example: Cancer, heart disease, diabetes, arthritis, etc.) and when, and were they treated successfully? (Immediate family is most applicable here)
_____
_____

What is your **stress level** like from home _____ What is you **stress level** like from work _____
More emotional stressors or physical stressors? _____

How is your sleep _____ Any sleep aid use?_____
_____

FEMALES ONLY Previous pregnancies? ____ Number ____ Difficulty with labors? _____ 1st day of last menstrual period _____ If in menopause; was it natural or surgically induced _____ If Surgical-Why? _____ Are you on hormone therapy?
_____

Habits

Do you drink alcohol? _____ What do you drink and how often_____
Do you smoke or have you? When did you start _____ How many per day____ When did you quit _____
Any recreational drug use What type_____ When did you start_____ Times per day_____
Do you drink Coffee? Decaf or Regular? How many cups a day _____
Do you drink Soda? Diet or Regular? Kind_____ How many per day_____
Do you drink Water? How many glasses per day_____
Do you do any type of exercise? How often and for how long_____
How is your diet? _____
Any sugary foods? How often do you have sugary foods _____
Any artificial sweeteners? How often do you have these _____
How is your appetite? _____

Patient Name _____ DOB _____

Review of Systems Please mark the following for ongoing/current (C) or past (P)

GENERAL SYMPTOMS
- Tremors
- Twitching
- Convulsions
- Dizziness
- Depression
- Headache/Migraine
- Nervousness
- Numbness
- Fatigue

MUSCLES & JOINTS
- Low Back Problems
- Joint Dislocation
- Neck Problems
- Arm/Hand Problems
- Leg/Foot Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Degenerative Disc Dis
- Disc Herniation
- Walking Problems
- Scoliosis
- Broken Bones
- Arthritis
- Sciatica

CARDIO-VASCULAR
- High Blood Pressure
- Heart Attack
- Chest Pain
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins
- Fainting
- Low Blood Pressure
- Shortness of Breath
- Pacemaker

NEUROLOGICAL
- Anxiety
- Mood Swings
- Memory Loss
- Phobia
- Mental Disorder
- Multiple Sclerosis
- Epilepsy
- Balance Issue
- Cerebral Palsy

EAR/NOSE/THROAT
- Ear Discharge/Draina
- Deafness
- Earache
- Ear Noises (ring/buzz)
- Thyroid Dysfunction
- Frequent Colds
- Jaw Problems
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision/Blurred V
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL
- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver Issue
- Weight Loss/Gain
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Heartburn
- Black Stool
- Bloody Stool
- Oily Stool
- Blood in Urine
- Hernia

SYSTEMIC
- Chills
- Fever
- Night Sweats
- Loss of Sleep
- AIDS/HIV
- Cancer
- Tuberculosis
- Hepatitis
- Diabetes
- Measles
- Loss of Smell/Taste
- Anemia

RESPIRATORY
- Bronchitis
- Emphysema
- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm
- Wheezing

GENITO-URINARY
- Blood in Urine
- Frequent Urination
- Kidney Infection/Stones
- Painful Urination
- Prostate Problems
- Loss of Bladder/Bowel Control
- Venereal Disease

SKIN OR ALLERGIES
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- __ Sensitive Skin
- Allergy _____
- Gout
- Boils

FOR WOMEN ONLY
- Birth Control -hormonal
- Birth Control -physical
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Period
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N
- Tubal Ligation
- Lumps in Breast

SYSTEMIC CONTINUED
- Mumps
- Polio
- Chicken Pox
- Rheumatic Fever
- Muscular Dystrophy
- Pleurisy
- Sensitive to Light/Sound
- Alcoholism

Patient Signature _____ Date _____